NICE National Institute for Health and Care Excellence

NICE quality standard

Asthma

Quality standard

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This standard is based on NG80.

This standard should be read in conjunction with QS10, QS15, QS43, QS120, QS174, QS140, QS118, QS196 and QS119.

Quality statements

Statement 1 People aged 5 years and over with suspected asthma have objective tests to support diagnosis. **[2013, updated 2018]**

Statement 2 People aged 5 years and over with asthma discuss and agree a written personalised action plan. **[2013, updated 2018]**

Statement 3 People with asthma have their asthma control monitored at every asthma review. **[2013, updated 2018]**

Statement 4 People who receive treatment in an emergency care setting for an asthma attack are followed up by their general practice within 2 working days of discharge. **[2013, updated 2018]**

Statement 5 People with suspected severe asthma are referred to a specialist multidisciplinary severe asthma service. **[2013, updated 2018]**

In 2018, this quality standard was updated and statements prioritised in 2013 were updated (2013, updated 2018). For more information, see update information.

Statements from the 2013 quality standard for asthma that are still supported by the evidence may still be useful at a local level:

- Adults with new onset asthma are assessed for occupational causes.
- People with asthma are given specific training and assessment in inhaler technique before starting any new inhaler treatment.
- People with asthma receive a structured review at least annually.
- People with asthma who present with an exacerbation of their symptoms receive an objective measurement of severity at the time of presentation.

- People aged 5 years or older presenting to a healthcare professional with a severe or life-threatening acute exacerbation of asthma receive oral or intravenous steroids within 1 hour of presentation.
- People admitted to hospital with an acute exacerbation of asthma have a structured review by a member of a specialist respiratory team before discharge.

The 2013 quality standard for asthma is available as a pdf.

NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE Pathway on patient experience in adult NHS services), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing asthma services include:

- Emergency and acute medical care in over 16s. NICE quality standard 174
- Transition from children's to adults' services. NICE quality standard 140
- Medicines optimisation. NICE quality standard 120
- Smoking: supporting people to stop. NICE quality standard 43
- Chronic obstructive pulmonary disease in adults. NICE quality standard 10

A full list of NICE quality standards is available from the quality standards topic library.

Quality statement 1 (developmental): Objective tests to support diagnosis

Developmental quality statements set out an emergent area of cutting-edge service delivery or technology currently found in a minority of providers and indicating outstanding performance. They will need specific, significant changes to be put in place, such as redesign of services or new equipment.

Quality statement

People aged 5 years and over with suspected asthma have objective tests to support diagnosis. **[2013, updated 2018]**

Rationale

Asthma can be misdiagnosed, which means that people with untreated asthma are at risk of an asthma attack, and people who do not have asthma receive unnecessary drugs. Following taking an initial history and assessment, objective tests can help healthcare professionals to diagnose asthma correctly in people over 5 years. There is no single objective test to diagnose asthma and the correct initial test may identify the need for further tests. The basis on which a diagnosis of asthma is made should be documented. Children under 5 are unable to perform objective tests, and treatment should be based on observation and clinical judgement until the child is old enough for objective testing.

Quality measures

Structure

a) Evidence of local arrangements or referral pathways to asthma diagnostic hubs to ensure that people aged 5 years and over with suspected asthma have objective tests to support diagnosis.

Data source: Local data collection, for example, service protocol or referral pathways.

b) Evidence of local arrangements to ensure that healthcare professionals are trained and competent to carry out and interpret objective tests to support diagnosis of asthma.

Data source: Local data collection, for example, training records and competency assessments.

c) Evidence of local processes to ensure that the basis for a diagnosis of asthma is documented.

Data source: Local data collection, for example, service protocol.

Process

a) Proportion of adults aged 17 years and over with newly diagnosed asthma who have a record of a fractional exhaled nitric oxide (FeNO) test to support diagnosis.

Numerator – the number in the denominator who have a record of a FeNO test to support diagnosis.

Denominator – the number of adults aged 17 years and over with newly diagnosed asthma.

Data source: Local data collection, for example, audit of patient health records.

b) Proportion of people aged 5 years and over with newly diagnosed asthma who have a record of a spirometry test to support diagnosis.

Numerator – the number in the denominator who have a record of a spirometry test to support diagnosis.

Denominator – the number of people aged 5 years and over with newly diagnosed asthma.

Data source: Local data collection, for example, audit of patient health records.

c) Proportion of people aged 5 years and over with newly diagnosed asthma who have a record of the objective tests used to support diagnosis.

Numerator – the number in the denominator who have a record of the objective tests used to support diagnosis.

Denominator – the number of people aged 5 years and over with newly diagnosed asthma.

Data source: Local data collection, for example, audit of patient health records.

Outcome

Prevalence of asthma.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as GP practices, community health services and hospitals) ensure that processes are in place for people aged 5 years and over with suspected asthma to have objective tests to support diagnosis. Depending on local arrangements, this may involve referral to a local asthma diagnostic hub. Service providers ensure that healthcare professionals are trained and competent in performing and interpreting objective tests, and that processes are in place to record the basis for a diagnosis of asthma (for example, see NICE's asthma diagnosis implementation data collection sheet).

Healthcare professionals (such as doctors, nurses and pharmacists) are aware of local arrangements for accessing objective tests for asthma and ensure that people aged 5 years and over with suspected asthma have objective tests to support diagnosis. Healthcare professionals record the basis for a diagnosis of asthma.

Commissioners (clinical commissioning groups and NHS England) commission services that ensure that people aged 5 years and over with suspected asthma have objective tests to support diagnosis. Commissioners consider whether local diagnostic hubs for asthma would optimise investment in equipment and staff training.

People aged 5 years and over with suspected asthma have tests to confirm if they have asthma. An accurate diagnosis will make sure they get the treatment they need.

Source guidance

Asthma: diagnosis, monitoring and chronic asthma management. NICE guideline NG80 (2017, updated 2020), recommendations 1.1.2 and 1.3.22

Definitions of terms used in this quality statement

Objective tests to diagnose asthma

Tests carried out to help determine whether a person has asthma, the results of which are not based on the person's symptoms, for example, tests to measure lung function or evidence of inflammation. There is no single objective test to diagnose asthma. Objective tests should be performed in accordance with the algorithms in the NICE guideline.

The initial test for children and young people aged 5 to 16 years is spirometry. A bronchodilator reversibility (BDR) test should be considered if spirometry shows an obstruction. If diagnostic uncertainty remains after spirometry and BDR, consider a FeNO test. If diagnostic uncertainty remains after FeNO, monitor peak flow variability for 2 to 4 weeks.

The initial tests for adults aged 17 years and over are FeNO followed by spirometry. A BDR test should be carried out if spirometry shows an obstruction. If diagnostic uncertainty remains after FeNO, spirometry and BDR, monitor peak flow variability for 2 to 4 weeks. If diagnostic uncertainty remains after measuring peak flow variability, refer for a histamine or methacholine direct bronchial challenge test. [NICE's guideline on asthma, terms used in this guideline and algorithms B and C]

Suspected asthma

A potential diagnosis of asthma based on symptoms and response to treatment that has not yet been confirmed with objective tests. [NICE's guideline on asthma, terms used in this guideline]

Equality and diversity considerations

If a child is unable to perform objective tests when they are 5 years, healthcare professionals should continue treatment based on observation and clinical judgement and should try doing the tests again every 6 to 12 months until the child is able to perform the tests. If it is decided that a child, adult or young person with symptoms suggesting asthma cannot perform a particular test, healthcare professionals should try to perform at least 2 other objective tests and diagnose suspected asthma based on symptoms and any positive objective test results.

Some people with learning disabilities or mental health problems may need additional support to help them to perform objective tests to diagnose asthma.

Quality statement 2: Written personalised action plan

Quality statement

People aged 5 years and over with asthma discuss and agree a written personalised action plan. **[2013, updated 2018]**

Rationale

Involving people with asthma (including their families and carers as appropriate) in developing a written personalised action plan can help them to respond to changes in their symptoms, enabling them to self-manage their asthma and reduce the risk of serious asthma attacks and hospital admission. Regular reviews of the action plan with a healthcare professional can help to prevent complications arising.

Quality measures

Structure

a) Evidence of a local framework and guidance for healthcare professionals on providing asthma education and developing a written personalised action plan for people aged 5 years and over with asthma.

Data source: Local data collection, for example, service protocol.

b) Evidence of local arrangements to ensure that people aged 5 years and over with asthma discuss and agree a written personalised action plan with their healthcare professional.

Data source: Local data collection, for example, service protocol.

Process

a) Proportion of people aged 5 years and over with asthma who have a record of a discussion to agree a written personalised action plan.

Numerator – the number of people in the denominator who have a record of a discussion to agree a written personalised action plan.

Denominator – the number of people aged 5 years and over with asthma.

Data source: Local data collection, for example, audit of patient health records.

b) Proportion of people aged 5 years and over with asthma who have a documented written personalised action plan.

Numerator – the number of people in the denominator who have a documented written personalised action plan.

Denominator – the number of people aged 5 years and over with asthma.

Data source: Local data collection, for example, audit of patient health records.

Outcome

a) Rate of hospital attendance or admission for an asthma attack.

Data source:NHS Digital's Hospital Episode Statistics includes data on admissions and A&E attendances for asthma attack.

b) Satisfaction of people with asthma aged 5 years and over and their family and carers (as appropriate) that they are able to self-manage their condition and their asthma is well controlled.

Data source: Local data collection, for example, patient and carer surveys.

What the quality statement means for different audiences

Service providers (such as GP practices, community health services and hospitals) ensure that processes are in place to involve people aged 5 years and over with asthma, and their family and carers as appropriate, in developing a written personalised action plan and to provide education to help them self-manage their asthma. Service providers ensure that written personalised action plans are reviewed regularly, including after an asthma attack.

Healthcare professionals (such as doctors, nurses, healthcare assistants and pharmacists) involve people aged 5 years and over with asthma, and their family and carers as appropriate, in developing a written personalised action plan and provide education to help them self-manage their asthma. Healthcare professionals regularly involve people with asthma in reviewing and updating their written personalised action plan, including after an asthma attack.

Commissioners (clinical commissioning groups and NHS England) commission services that involve people aged 5 years and over with asthma, and their family and carers as appropriate, in developing and reviewing a written personalised action plan and provide education to help them self-manage their asthma. Commissioners should ensure consistency by providing a local framework and guidance to healthcare professionals on developing and reviewing written personalised action plans and providing education for people with asthma.

People aged 5 years and overwith asthma have their own asthma care plan, which helps them take their asthma medicines and know what to do if the medicines are not working (with support from their family and carers as appropriate). Their healthcare professional gives them (and their family and carers as appropriate) information about asthma, involves them in developing the plan and helps them to use it. The care plan is reviewed regularly with the person's healthcare professional and also reviewed after an asthma attack.

Source guidance

Asthma: diagnosis, monitoring and chronic asthma management. NICE guideline NG80 (2017, updated 2020), recommendation 1.10.1

Definitions of terms used in this quality statement

Written personalised action plan

A written personalised action plan (such as Asthma UK's asthma action plan) should be tailored to the person with asthma, enabling them to recognise when symptoms are worse. The plan should set out actions to be taken if asthma control deteriorates and who to contact. [BTS/SIGN's British guideline on the management of asthma, recommendation 5.2.2, and expert opinion]

Equality and diversity considerations

Healthcare professionals should have a discussion with family or carers of children under 5 years with symptoms of asthma to agree if a written personalised action plan would be helpful.

The personalised action plan should be provided in an accessible format and tailored to meet individual needs, taking into consideration a person's capacity and their ability to care for themselves. Additional support may be needed for people with learning disabilities to ensure that they can be involved in the discussion and are able to understand how to use their plan.

Quality statement 3: Monitoring asthma control

Quality statement

People with asthma have their asthma control monitored at every asthma review. **[2013, updated 2018]**

Rationale

Monitoring of asthma control at every asthma review will identify if control is suboptimal. If suboptimal asthma control is identified, the person should have an assessment to identify possible reasons for this, including adherence and inhaler technique, before their treatment is adjusted. Support and education can be provided to improve adherence and inhaler technique. Monitoring asthma control and addressing any problems identified will improve quality of life and reduce the risk of serious asthma attacks and hospital admissions.

Quality measures

Structure

a) Evidence that tools, such as a validated questionnaire, are used locally for monitoring asthma control in adults.

Data source: Local data collection, for example, service specifications.

b) Evidence that spirometry or peak flow variability testing are used locally for monitoring asthma control in people aged 5 and over.

Data source: Local data collection, for example, service specifications.

c) Evidence of local arrangements to ensure that people with asthma have their asthma control monitored at every asthma review.

Data source: Local data collection, for example, service protocol.

Process

a) Proportion of people with asthma who had an asthma review within the past 12 months.

Numerator – the number in the denominator who had an asthma review within the past 12 months.

Denominator – the number of people with asthma.

Data source: Local data collection, for example, audit of patient heath records.

b) Proportion of asthma reviews that include monitoring of asthma control.

Numerator – the number in the denominator that include monitoring of asthma control.

Denominator – the number of asthma reviews.

Data source: Local data collection, for example, audit of patient heath records.

Outcome

a) Proportion of people with asthma prescribed more than 12 short-acting beta agonist (SABA) reliever inhalers within the past 12 months.

Data source: Local data collection, for example, electronic prescribing data. The Pharmaceutical services negotiating committee's Pharmacy quality scheme collects data on referrals for an asthma review for people with asthma dispensed more than 6 short-acting bronchodilator inhalers without any corticosteroid inhaler within a 6-month period.

b) Rate of hospital attendance or admission for asthma attack.

Data source:NHS Digital's Hospital Episode Statistics includes data on admissions and A&E attendances for asthma attack.

What the quality statement means for different audiences

Service providers (such as GP practices, community health services and hospitals) ensure that processes are in place for people with asthma to have their asthma control monitored at every

asthma review. Service providers ensure that if asthma control is suboptimal, processes are in place for adherence and inhaler technique to be assessed before treatment is adjusted. Service providers ensure that staff are trained to use the tools and tests needed to monitor asthma control and to assess adherence and inhaler technique.

Healthcare professionals (such as doctors, nurses, healthcare assistants and pharmacists) monitor asthma control at every asthma review. If control is suboptimal they assess adherence and inhaler technique before adjusting treatment.

Commissioners (clinical commissioning groups and NHS England) commission services that monitor asthma control at every asthma review. Commissioners ensure that tools, such as a validated questionnaire, and spirometry or peak flow variability testing, are available for monitoring asthma control.

People with asthma have their asthma control checked when they have a review of their asthma. If their asthma is not well controlled, they get support to make sure they are using their medicines correctly, for example, a check of how they are using their inhaler. If this doesn't help, they may have their medicines or inhaler changed to help prevent asthma attacks.

Source guidance

Asthma: diagnosis, monitoring and chronic asthma management. NICE guideline NG80 (2017, updated 2020), recommendations 1.13.1 and 1.13.3

Definitions of terms used in this quality statement

Monitoring asthma control

Consider using a validated questionnaire, such as the Asthma Control Questionnaire or Asthma Control Test, to monitor asthma control in adults. Asthma control should be monitored in people aged 5 and over using either spirometry or peak flow variability testing. [NICE's guideline on asthma, recommendations 1.13.2 and 1.13.3]

Asthma review

Any asthma review, including review after an asthma attack and annual asthma review. [Expert opinion]

Equality and diversity considerations

Healthcare professionals using a validated questionnaire to monitor asthma control should ensure it is provided in a suitable format to meet individual needs. People with a learning disability or low literacy levels may need additional support to ensure that they understand what is being asked and can take part in the discussion.

Quality statement 4: Follow-up by general practice after emergency care

Quality statement

People who receive treatment in an emergency care setting for an asthma attack are followed up by their general practice within 2 working days of discharge. [**2013, updated 2018**]

Rationale

People who have recently had emergency care for an asthma attack may be at risk of another attack. Timely follow-up in general practice after discharge from emergency care allows healthcare professionals to check that the asthma is responding to treatment, to explore the possible reasons for the attack and to give support and advice about reducing the risk of further attacks.

Quality measures

Structure

a) Evidence of local arrangements to ensure that emergency care settings notify the person's general practice following treatment for an asthma attack.

Data source: Local data collection, for example, service protocols.

b) Evidence of local arrangements to ensure that general practices follow-up people treated in an emergency care setting for an asthma attack within 2 working days of discharge.

Data source: Local data collection, for example, service protocol.

Process

a) Proportion of cases of asthma attack treated in an emergency care setting notified to the person's general practice.

Numerator – the number in the denominator notified to the person's general practice.

Denominator – the number of cases asthma attack treated in an emergency care setting.

Data source: Local data collection, for example, audit of patient health records. Data on follow-up requests is included in the National Asthma and COPD Audit Programme (NACAP) adult asthma audit and NACAP children and young people asthma audit as an element of the patient's discharge.

b) Proportion of notifications of asthma attack treated in an emergency care setting followed up by a general practice within 2 working days of discharge.

Numerator – the number in the denominator that are followed up by a general practice within 2 working days of discharge.

Denominator – the number of notifications of asthma attack treated in an emergency care setting.

Data source: Local data collection, for example, audit of patient health records.

Outcome

a) Rate of re-attendance within 7 days of a previous attendance in emergency care for asthma.

Data source: Local data collection, for example, audit of patient health records. Data on A&E re-attendance is included in NHS Digital's Accident and Emergency Quality Indicators.

b) Rate of hospital attendance or admission for asthma attack.

Data source:NHS Digital's Hospital Episode Statistics includes data on admissions and A&E attendances for asthma attack.

c) Mortality rate for people with asthma.

Data source: Local data collection, for example, audit of patient health records. National data on the under 75 mortality rate from respiratory disease is included in NHS Outcomes Framework – indicator 1.2 available from NHS Digital's Clinical indicators.

What the quality statement means for different audiences

Service providers (such as A&E departments, out-of-hours services, walk-in centres and general

practices) ensure that processes are in place to notify the person's general practice when treatment for an asthma attack has been provided in an emergency care setting. Once notified, general practices ensure follow-up takes places within 2 working days of discharge. General practices ensure that staff who follow-up people who have had an asthma attack are trained in asthma care.

Healthcare professionals (such as doctors, nurses, pharmacists and healthcare assistants) notify the person's general practice when they provide treatment in an emergency care setting for an asthma attack. Healthcare professionals in general practices ensure that follow-up takes place within 2 working days of discharge from emergency care.

Commissioners (clinical commissioning groups and NHS England) commission emergency care services that have processes in place to notify the person's general practice when treatment is provided for an asthma attack. Commissioners ensure that there is sufficient capacity for general practice to follow-up within 2 working days of discharge. Commissioners could consider introducing a local quality improvement scheme to encourage the pathway to be established.

People who have emergency treatment for an asthma attack are checked by a healthcare professional at their GP surgery within 2 working days of discharge. This is to check that their treatment is working and help them to understand why their asthma got worse and how to stop it happening again.

Source guidance

British guideline on the management of asthma. British Thoracic Society and Scottish Intercollegiate Guidelines Network guideline 158 (2019), recommendations 9.6.3, 9.9.7, and annexes 3 and 7

Equality and diversity considerations

Healthcare professionals in emergency care should ensure that alternative follow-up arrangements are made for people who are not registered with a general practice, for example, because they are homeless.

Quality statement 5 (developmental): Suspected severe asthma

Developmental quality statements set out an emergent area of cutting-edge service delivery or technology currently found in a minority of providers and indicating outstanding performance. They will need specific, significant changes to be put in place, such as redesign of services or new equipment.

Quality statement

People with suspected severe asthma are referred to a specialist multidisciplinary severe asthma service. **[2013, updated 2018]**

Rationale

People with suspected severe asthma need specialist assessment to confirm a diagnosis of severe asthma. Specialist assessment is important to revisit adherence to treatment, exclude other causes of persistent symptoms and ensure the most appropriate treatment. Specialist care can help to improve asthma control, prevent asthma attacks and reduce harmful long-term dependence on oral corticosteroids.

Quality measures

Structure

a) Evidence that specialist multidisciplinary severe asthma services are available for people with suspected severe asthma.

Data source: Local data collection, for example, service specifications for children and young people, and adults.

b) Evidence of local arrangements to ensure that people with suspected severe asthma are referred to a specialist multidisciplinary severe asthma service.

Data source: Local data collection, for example, service protocols and referral pathways.

Process

Proportion of people with suspected severe asthma who are referred to a specialist multidisciplinary severe asthma service.

Numerator – the number in the denominator who are referred to a specialist multidisciplinary severe asthma service.

Denominator – the number of people with suspected severe asthma.

Data source: Local data collection, for example, audit of patient health records.

Outcome

a) Rate of hospital attendance or admission for an asthma attack.

Data source:NHS Digital's Hospital Episode Statistics includes data on admissions and A&E attendances for asthma attack.

b) Proportion of people with asthma who have 2 or more courses of high-dose oral corticosteroids per year.

Data source: Local data collection, for example, electronic prescribing data.

What the quality statement means for different audiences

Service providers (such as hospitals) ensure that processes are in place to identify people with suspected severe asthma so that they can be referred to a specialist multidisciplinary severe asthma service. Service providers ensure that a diagnosis of asthma is made, and adherence and comorbidities are addressed before a referral is made.

Healthcare professionals (such as doctors and nurses) are aware of local referral pathways for severe asthma and refer people with suspected severe asthma to a specialist multidisciplinary severe asthma service. Healthcare professionals ensure that a diagnosis of asthma is made, and adherence and comorbidities are addressed before making a referral. Healthcare professionals ensure that people with suspected severe asthma know what to expect when they are referred.

Commissioners (NHS England) commission specialist multidisciplinary severe asthma services for adults and children and young people and ensure referral pathways are in place. Commissioners ensure that providers identify people with suspected severe asthma so that they can be referred. Commissioners ensure that specialist services have sufficient capacity to meet the demand for assessments for people with suspected severe asthma.

People with suspected severe asthma are referred to a service that specialises in managing severe asthma so that the reasons for their asthma and their treatment can be reviewed.

Source guidance

British guideline on the management of asthma. British Thoracic Society and Scottish Intercollegiate Guidelines Network guideline 158 (2019), recommendation 10.1

Definitions of terms used in this quality statement

Severe asthma

When a diagnosis of asthma is confirmed and comorbidities have been addressed, severe asthma is defined as asthma that needs treatment with the medicines suggested for steps 4 to 5 in the Global Initiative for Asthma (GINA) guideline (a high-dose inhaled corticosteroid [ICS] with a long-acting beta 2-agonist [LABA] or leukotriene modifier or theophylline) for the previous year or systemic corticosteroids for 6 months or more of the previous year to prevent it from becoming 'uncontrolled' (that is, controlled asthma that worsens on tapering of these high doses of ICS or systemic corticosteroids [or additional biologics]) or that remains 'uncontrolled' despite this therapy. 'Uncontrolled' is defined as at least 1 of the following:

- Poor symptom control: Asthma Control Questionnaire consistently greater than 1.5 or Asthma Control Test less than 20.
- Frequent severe exacerbations: 2 or more bursts of systemic corticosteroids in the previous year.
- Serious asthma attacks: at least 1 hospitalisation, ICU stay or mechanical ventilation in the previous year.
- Airflow limitation: after appropriate bronchodilator withhold FEV1 less than 80% predicted (in the face of reduced FEV1/FVC defined as less than the lower limit of normal).

[Global Initiative for Asthma's Global strategy for asthma management and prevention, European

Respiratory Society/American Thoracic Society International guidelines on definition, evaluation and treatment of severe asthma, and expert opinion]

Specialist multidisciplinary severe asthma service

A dedicated multidisciplinary service with a team experienced in the assessment and management of severe asthma. The service requirements for adults are set out in NHS England's Specification for specialised respiratory services (adult) – severe asthma. The service requirements for children are set out in NHS England's Specification for paediatric medicine: respiratory with additional information provided in the 2016/17 Prescribed Specialised Services Commissioning for Quality and Innovation (CQUIN) Scheme for difficult to control asthma assessment in 12 weeks.

Equality and diversity considerations

Healthcare professionals should ensure that people with learning disabilities are referred to a specialist service if severe asthma is a possibility but it has not been possible to assess all relevant criteria.

Update information

September 2018: This quality standard was reviewed and statements prioritised in 2013 were updated.

Statements are marked as **[2013, updated 2018]** if the statement covers an area for quality improvement included in the 2013 quality standard and has been updated.

Statements numbered 1, 3, 6, 10 and 11 in the 2013 version have been updated. Statements from the 2013 version (numbered 2, 4, 5, 7, 8 and 9) that are no longer considered national priorities for improvement, but may still be useful at a local level, are listed in the quality statements section.

The 2013 quality standard for asthma is available as a pdf.

Minor changes since publication

February 2020: Evidence source references for statements 1 to 3 were amended to reflect the updated NICE guideline on asthma.

November 2019: References for the evidence sources for statements 4 and 5 were amended to reflect the updated BTS/SIGN British guideline on the management of asthma.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standard advisory committees for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

This quality standard has been included in the NICE Pathway on asthma, which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- health-related quality of life
- sickness absence from work/school
- frequency of asthma attacks
- A&E attendances
- hospital admissions
- mortality.

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

- Adult social care outcomes framework
- NHS outcomes framework
- Public health outcomes framework for England
- Quality framework for public health.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the following resource impact products for the NICE guideline on asthma to help estimate local costs:

- resource impact report
- resource impact template: asthma diagnosis and monitoring
- resource impact template: chronic asthma management.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Association of Respiratory Nurse Specialists
- Royal College of Nursing (RCN)
- Royal College of Paediatrics and Child Health
- Asthma UK